Evaluating and Monitoring the Reach, Quality, and Consistency of Crisis Counseling Programs

Manual and Toolkit

Version 1.1

Prepared for:

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and Collaborating States

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Table of Contents

Introduction to this Manual and the Crisis Counseling Program (CCP)

What is the CCP?

The Crisis Counseling Assistance and Training Program (commonly referred to as the Crisis Counseling Program or CCP) is funded by the Federal Emergency Management Agency (FEMA) through the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, as amended by Public Law 100-707). Crisis counseling programs aim to meet short-term mental health needs of affected communities through counseling, outreach, public education, training, and referral. In a typical year, there are approximately 10-12 crisis counseling programs, but in some years (such as after Hurricane Katrina), there are many more. The crisis counseling program has provided brief mental health services to millions of disaster survivors since its inception and has become an important model for response to a variety of catastrophic events.

Who administers the CCP?

The CCP is a partnership between FEMA and the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). CMHS provides states with consultation and technical assistance in implementing the program.

What led to this manual?

Collecting accurate information about services and service recipients is essential for monitoring and evaluating crisis counseling programs. In the past, states developed their own procedures and forms. This process was time-consuming and often missed important questions. CMHS recognized that standard reporting methods need to be implemented in order to make the data meaningful and more accurate across disasters and across states. In 2005, CMHS introduced a “toolkit” to standardize program activities, definitions, and data collection. These tools were evaluated and approved by the Office of Management and Budget in September 2005.

How is the manual organized?

The manual is organized as a series of questions that counselors, supervisors, program planners, and data managers might ask about program evaluation and monitoring. Not every question is relevant to everyone who might use this manual. When the question is not of interest to the reader, the answer may be safely skipped.

How should it be used?

The manual was created to serve two functions. First, it should be used for training counselors and other program staff about CCP evaluation. Second, it can be used as an ongoing reference work when questions arise.

Who created the manual?

The manual and toolkit were developed by researchers at the National Center for PTSD. The toolkit was strongly influenced by the earlier toolkit created by CMHS staff and especially by the enhanced services introduced by Project Liberty, New York State's CCP after the terrorist attacks of September 11, 2001. Sheila Donahue, April Naturale, and Chip Felton played major roles in creating Project Liberty's tools. Lead researchers at NCPTSD involved in creating this toolkit and manual were Fran Norris, Craig Rosen, Cindy Elrod, Helena Young, and Jessica Hamblen, who worked in close collaboration with CMHS staff, especially Seth Hassett and Cecilia Casale.

Understanding Program Evaluation

What is program evaluation?

Program evaluation refers to systematic efforts to collect, analyze, and interpret information about the delivery or outcomes of interventions. Program monitoring typically relies on easily measurable indicators that can be tracked over time, such as the number of counseling encounters or client satisfaction.

Why is it important?

The continuing recognition, acceptance, and support of the CCP depends, at least in part, on its ability to show sponsors and other interested parties that it delivers the services it intends to deliver and that survivors benefit from the services provided. Program achievements are documented through program evaluation. A useful management tool, evaluation helps program administrators to determine if the project is proceeding according to plan so that they can make mid-course corrections when needed.

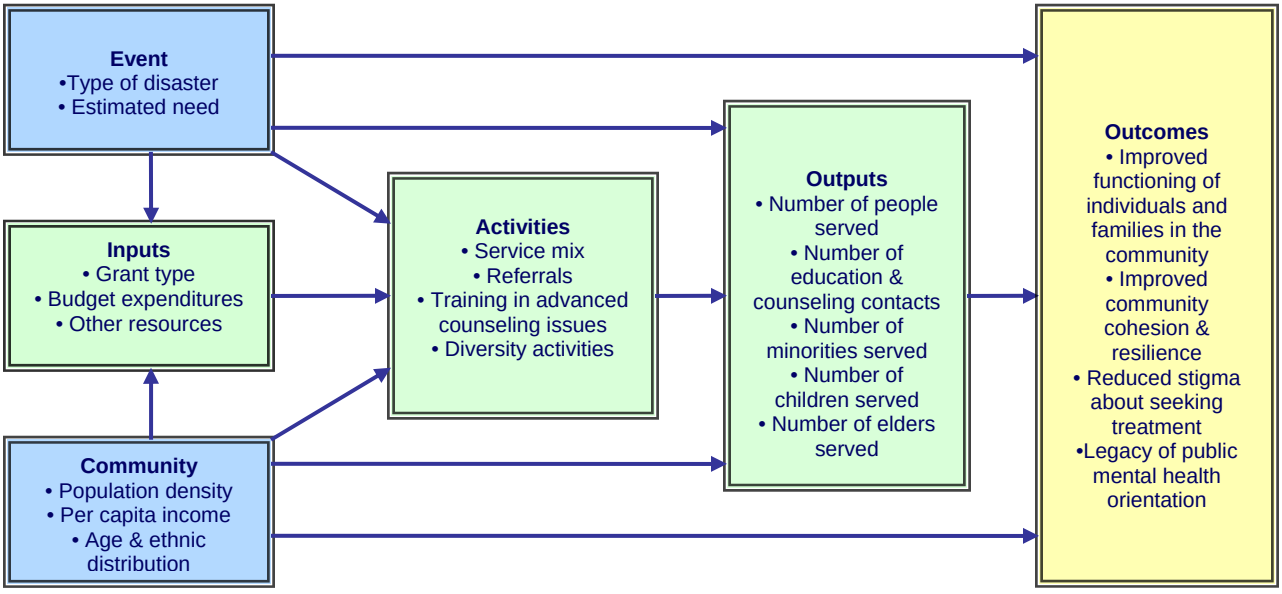
How are results used?

Ultimately, evaluation is not about gathering data but about using data to draw conclusions. Evaluation results are open to interpretation. A program may reach a large number of people but only a fraction of the total population at risk. Program results may involve trade-offs. For example, counselors who tirelessly throw themselves into their work may realize greater consumer satisfaction but experience greater burnout. An innovative program may serve fewer clients but attain better results for those it does serve. Different stakeholder groups may judge these exchanges differently.

Evaluations are useful only if their results are communicated. Program managers should regularly share results in staff meetings, quarterly updates, or even graphs posted on the wall. This feedback can then facilitate discussion on means to improve services. For example, noting that one outreach team dramatically increased its number of counseling encounters may promote sharing by field workers of an innovative outreach technique. Or it might reveal that the team is counting very brief contacts as counseling, allowing the supervisor to give staff feedback about ways to deepen their discussions with survivors. It is critical that results are shared in a climate that is supportive and curious ("What might these data be telling us?") not rigid and punitive.

How does it work?

Program evaluation or program monitoring is much more likely to be useful and meaningful if it is grounded in an understanding of how a program operates: what resources it has, what it does, what it produces, and what societal benefits it is trying to achieve. This understanding is often termed a "program theory" or "logic model." A program logic model typically includes inputs, activities, outputs, and outcomes, as illustrated below. The nature of the inputs, activities, outputs, and outcomes, however, may depend upon characteristics of the disaster (such as its type and severity) and characteristics of the community (such as its density and wealth).



An example program theory and logic model (bulleted items are illustrative, not exhaustive).

What are inputs?

Inputs are the resources available to the program for use in achieving its goals. Some inputs are tangible resources: funding, program staff, office space, office supplies and other consumables, transportation, etc. Others are less concrete, but equally important: the skills and expertise of program staff; the relationships between staff and local community leaders; and the delineation of responsibilities among the different agencies involved. Lack of one or more of these needed contributions can greatly limit an organization's ability to deliver services.

What are activities?

Activities are the means used to bring about program objectives. Different programs aim for different mixes of education and counseling services according to what program leaders believe is best for their particular community. Advanced training helps counselors do their jobs more effectively especially when the disaster is especially severe or complicated. Programs vary in their attention to diversity in the population. Programs also vary in the emphasis they place on identifying and referring individuals with more severe mental health needs.

What are outputs?

Outputs are the measurable units of product from a program's processes. Evaluations often focus on the outputs of the service delivery process, such as the number of individuals who received counseling and number of educational presentations made. In some cases, evaluations conclude with outputs, which are used as a proxy for outcomes. In other cases, outcomes need to be measured directly in order to assess whether services are truly having an impact.

What are outcomes?

Outcomes are the societal benefits. While outputs assess "how much" was done, outcomes focus on "how much good" was done. Outcomes can be considered in the short (immediate), intermediate, and long term. Immediate outcomes are those that can be observed directly after completing an activity. Intermediate outcomes are those that derive from immediate outcomes such as alleviation of psychiatric symptoms, reduced substance use, or improved role functioning. Long-term outcomes may include community cohesion, increased disaster preparedness, or community resilience in dealing with subsequent crisis.

Evaluation for Crisis Counseling Programs

What are the goals?

The evaluation of a crisis counseling program answers questions about three critical areas of performance: (1) program reach, (2) program quality, and (3) program consistency.

What is program reach?

How many people in the community were served by the program and what were their characteristics? The crisis counseling program aims to deliver services to large numbers of residents who are diverse in age, ethnicity, and needs. This aspect of the evaluation makes use of data from encounter logs and tallies that are routinely completed by counselors. The question is not only about the actual numbers of people served but also about how well these numbers align with the distribution of the state's population in the affected areas.

What is program quality?

Were the services perceived as appropriate and beneficial by consumers and providers? To assess service quality, consumer feedback is essential. This aspect of the evaluation relies upon brief anonymous surveys that capture service recipients' perceptions of service quality and personal improvements in functioning. (More detail about how this is done will follow.) Consumer feedback can also help program managers reach a better understanding of factors that influence recipients' perceptions of service quality. Because a different perspective on service quality can be obtained from service providers, the evaluation also includes a staff survey.

What is program consistency?

Many crisis counseling programs involve multiple jurisdictions such as counties, parishes, or townships. Did these areas vary in performance (i.e., reach and quality), and can this be explained by differences between areas in environmental, population, and experiential characteristics? Finding that some counties yield higher reach (in proportion to population), recipient satisfaction and/or provider satisfaction will inform project managers that further study or corrective action is needed. Advanced analyses can also contribute to knowledge about characteristics of settings (e.g., low population density) and events that make it more challenging to implement the crisis counseling program.

Data Collection with the CCP Toolkit

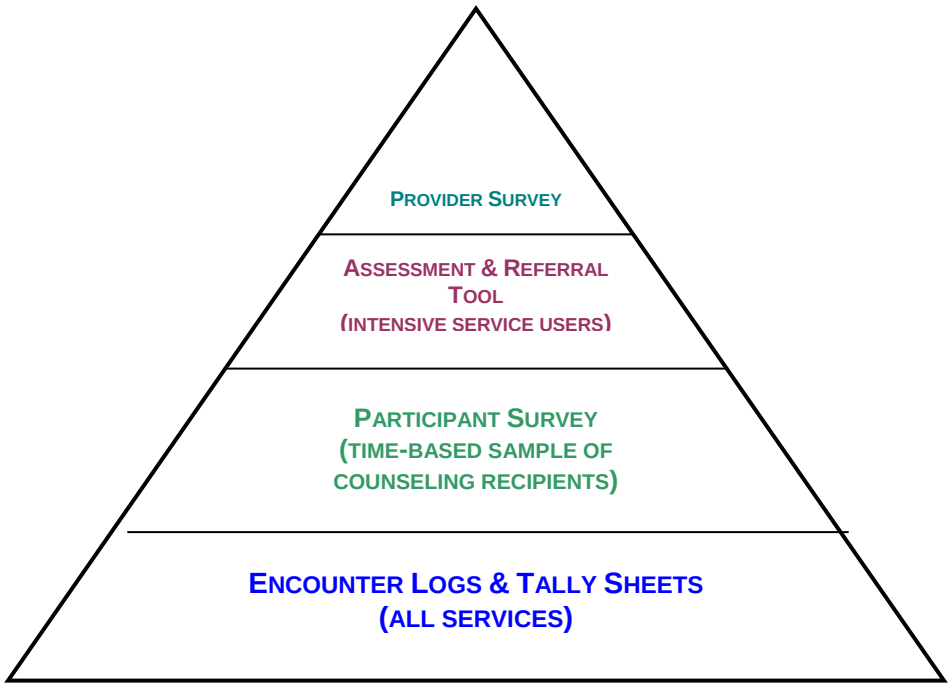
What are the sources of data?

Evaluation data come from many different sources. Data about event characteristics are found in the project's grant application. Data about community characteristics are derived from the census. Standard statistics for ethnicity, race, age distribution, and % poverty are recorded for each participating county. Some data about activities (such as types of staff training) are collected from program leaders. The remaining data on activities and outputs are collected throughout the program period by counselors using the CCP toolkit.

What is the toolkit?

The toolkit is a set of standardized forms that are completed by counselors and outreach workers. Because the data are collected in a consistent way from all programs, they can be uploaded into an ongoing national database that provides CMHS with a way of producing summary reports of services provided across all projects funded.

The structure of the toolkit might be described as a pyramid, involving tools that are used with decreasing frequency as one moves up from base to apex. The tools include counseling encounter logs for individuals and groups, weekly tallies, participant surveys, assessment & referral tools, and provider surveys.



CCP Evaluation Toolkit

Encounter Logs & Tallies

What are they for?

Encounter logs and tallies document all services delivered. They are the basic and living record of the program and serve many purposes for both program monitoring and program evaluation. It is very important for services to be counted in a standardized way across all areas served by the program. The forms are simple and take little time to complete. The three types of forms are: (1) Individual Crisis Counseling Services Encounter Log; (2) Group Crisis Counseling Services Encounter Log; and (3) Brief Educational and Supportive Services Weekly Tally Sheet. Each is described below. The forms and specific instructions are at the end of this manual.

Individual Crisis Counseling Services Encounter Log

What is individual counseling?

For the purposes of the evaluation, individual counseling is defined as an interaction that lasts at least 15 minutes and involves participant disclosure. This doesn't mean that it should be only 15 minutes or that shorter interactions are encouraged. There is a place on the form to record how long the particular encounter lasted.

What is in the individual log?

The Individual Crisis Counseling Services Encounter Log is a one-page form with 5 parts. The first "box" collects information on the date, place, type (first or follow-up), and duration of the encounter. The second box collects information on risk factors. The third box collects demographics using a consistent categorical scheme. Variables include age, ethnicity, sex, status as a parent or guardian, preferred language, and language of contact. The fourth box collects information on referrals, and the final box is for the signature of the local person who reviews forms for completeness.

When is it filled out?

The counselor completes the encounter log after the session is over but before moving to the next activity. This should take no more than two minutes. Waiting until the end of the day to fill them out is not acceptable because the counselor will not remember the answer to each question.

Some people are seen more than once by a counselor. The log is filled out for all counseling sessions, not only the first one, and the session number is noted.

How are families treated?

Sometimes “individual” counseling may involve more than one person. Perhaps the counselor has spoken to a married couple, a family, or even a couple of friends. This raises the issue of who received the counseling encounter. The service recipient is defined as any person who actively participated in the session (e.g., by verbally participating), not someone who is merely present. There may be two or more individuals helped at the same time. One encounter form is completed for each individual actively counseled.

Group Encounter Log

What is group counseling?

Group counseling and/or education can be very important and appropriate for disaster victims because of their shared experiences. The differences between group counseling and group education are subtle. In group counseling, service recipients do most of the talking; in group education, the counselor does most of the talking. For example, the counselor may have been asked to make a presentation about common reactions to disaster. (Also see note on families above.)

What’s in the group log?

Because of overlap in the type of information needed to describe them, group crisis counseling and group public education are captured on the same one-page form. A check mark at the top identifies the type of activity. The form has three parts. The first box collects information on the date, place, type, and duration of the encounter. In addition, the number of participants is recorded in this box. The second box asks the counselor to describe “group identities.” This section basically asks, “What makes the group a group?” Do members have a common occupation identity? Common age, disaster experience, religious identity, neighborhood identity or psychological problem? Or, is there no shared identity? The third box asks the counselor to describe the purpose of the group as one or more of the following: (1) education about common reactions, (2) education about community resources, (3) mutual support, (4) stress management or skills building, (5) conflict resolution, (6) community action, and (7) other. The final box is for the signature of the person who reviews the forms.

Brief Educational & Supportive Services Weekly Tally Sheet

What is the weekly tally for?

Counselors engage in many activities that are not captured by the individual or group encounter logs, but they are nonetheless important. For these other activities, counselors use the Brief Educational and Supportive Services Weekly Tally Sheet. This includes, for example, brief interactions, phone calls or email exchanges, and handing out brochures. Daily tallies and weekly totals are recorded.

Participant Survey

What is the participant survey?

This simple, short questionnaire (front and back of one sheet of paper) seeks feedback and other information from service recipients. The questions about services relate directly to the goals of crisis counseling, such as reassurance and being helped to find ways to cope. The first page concludes with a section on the ways in which the respondent was exposed to the disaster. The back of the survey collects information on event reactions. This brief measure (the SPRINT-E, described later as part of the Assessment/Referral Tool) taps symptoms of posttraumatic stress, depression, impaired functioning, and perceived need for additional help. A brief statement to respondents informs them that if they answered many questions with high scores, they might benefit from talking with a counselor about their reactions. The survey concludes with basic demographics.

Why is this necessary?

The survey plays three important functions for the program. First the survey provides information about service quality from the viewpoint of the recipient. Because it is not feasible to measure client outcomes, assessing client perceptions is the next best approach. The survey questions were informed by findings that disaster mental health services should be evaluated on the basis of their credibility, acceptability, accessibility, and confidentiality, among other characteristics.

Second, the survey provides the program with excellent information about the experiences and reactions of people they aim to serve in individual and group crisis counseling. It is one of the most important clinical records of the program. This information could lead to program adjustments to meet previously unrecognized needs.

Third, the survey helps planners learn about factors that influence perceptions of service quality. For example, are highly distressed individuals more or less positive about services than are less distressed individuals? Are members of different ethnic groups equally likely to report that they were treated with respect and sensitivity?

To whom is the survey given?

The questionnaire is given to a sample of persons for whom individual or group counseling services were provided (i.e., not for persons denoted only on a tally sheet).

When is the survey done?

During one week each quarter, all appropriate persons are asked to complete an anonymous survey. Excluding the time during which the program is getting up and running, the week within the quarter will be selected randomly. For example, surveys might be given out during the 10th, 23rd, 36th and 49th week of the program. In larger programs, different areas could be surveyed in different weeks to even out the work. The number of survey respondents is compared to the total number of people served in individual and group counseling during that week to estimate the response rate.

How is the survey done?

During the selected week for data collection, all appropriate persons are given a nice-looking packet containing the survey, a good quality pen, and a stamped pre-addressed envelope for returning the survey. The packets are to be distributed to supervisors one week in advance, and supervisors give counselors a set of packets to distribute.

What is the counselor's role?

Counselors distribute the survey. The importance of the counselor's attitude in this process cannot be overstated. The counselor must view this survey as the recipient's opportunity to tell the program (anonymously) how he/she feels about the services and his/her reactions. Counselors must covey that this information is critical to program planners. Counselors who view this as a burden will convey that attitude to potential respondents. It is essential that this form be given to each service recipient who should get it. Only then will the information be meaningful and useful to the program.

How are counselors protected?

Some counselors could understandably be concerned that the survey might be used to evaluate their own performance rather than that of the program as a whole. Some counselors work in areas where victims might be angry in general and could get lower ratings through no fault of their own. The form does not name a particular counselor, and the data are examined only in groupings, such as by county.

Aren't satisfaction data biased?

The positive bias in "consumer satisfaction" measures is well documented. People tend to answer in high ranges on consumer satisfaction surveys even when they have not improved. The tool addresses this by using a wide response format that allows room for variation at the top. Recipients answer each question on a 10-point scale where 1 is *the worst or least you can imagine* and 10 is *the best or most you can imagine*. Over time, the pooled data provide norms that can be used to interpret data from new programs.

Assessment & Referral Tool (Adult)

Why was this tool made?

Crisis counseling programs focus on short-term mental health interventions, but some people need either longer or more intensive interventions. Sometimes more intensive interventions are offered in collaboration with crisis counseling programs, but more often counselors need to rely on other community and state programs. Previous research suggested that making referrals to more intensive mental health services was a problem-area for many CCP providers. The issues spanned a range from limited availability of services (which, of course, cannot be addressed by means of a tool) to uncertainty about when to make referrals. This tool was created to help counselors make these referrals. The tool also helps to remind counselors that if individuals are not getting better, they should be referred for more intensive help.

When and for whom is it used?

Because symptoms of distress may initially be highly prevalent in disaster-stricken communities, the focus is on *continuing* postdisaster distress, defined as high distress present three months or later after the event. Beginning three months postdisaster, the tool is used with all adults who are intensive users of services. Intensive users are people who are receiving their third session of individual crisis counseling. In some cases, it is used again in the fifth session of counseling.

The adult tool is not intended for use with children and youth. States may choose to evaluate children and youth in a similar way, but those data are not part of the formal evaluation.

What's in the tool?

The referral tool is 2 pages, front and back of a single sheet of paper. Below the space for recording date and place of service, the form instructs the counselor to read an introductory statement. Risk categories are noted, followed by the assessment of event reactions. The back page guides the counselor though a script for referral and concludes with demographic information.

How are symptoms assessed?

The symptom (or reaction) section of the tool was adapted from the Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) developed by Connor and Davidson.[1] The 8-item SPRINT assesses the core symptoms of posttraumatic stress disorder (intrusion, avoidance, numbing, arousal), somatic malaise, stress vulnerability, and functional impairment.

With the permission of Connor and Davidson, the measure was modified for Project Liberty's use after the terrorist attacks of September 11, 2001 (SPRINT-expanded or SPRINT-E). The question regarding somatic malaise was replaced by one that assessed health behavior. Three items were added to expand the scope of the measure and to give it a stronger emphasis on functional impairment (not specific to PTSD). One of these questions assesses how "down or depressed" the respondent has been, one assesses how "distressed or bothered" the respondent is by his or her reactions, and one assesses the respondent's perceived ability to overcome problems without further assistance. One final question was added ("Is there any possibility that you might hurt or kill yourself?") but is not included in the score. Rather, it was included in the scale as a precaution and instructs the counselor to refer the respondent for immediate psychiatric intervention.

Is the measure good?

Data collected from 788 Project Liberty clients indicated that the SPRINT-E is a reliable measure of intervention need as expressed in distress and dysfunction. Internal consistency was excellent for the total sample (α = .93) and subsamples defined by various demographic characteristics and risk factors. Of those offered referral according to their score on the tool, 71% accepted. Among those offered referral, the number of intense reactions was by far the strongest predictor of referral acceptance.

How is it scored?

The tool is scored by counting the number of reactions valued 4 (*quite a bit*) or 5 (*very much*). The tool has been structured in a way that makes the scoring straightforward.

Is more guidance available?

A training manual on the process of assessing adults is available for counselors. It provides additional guidance on how to explain the purpose of assessment and how to answer questions that may arise.

[1] Connor, K., & Davidson, J. (2001). SPRINT: A brief global assessment of post-traumatic stress disorder. *International Clinical Psychopharmacology, 16,* 279-284.

Provider Survey

What is this survey for?

Service providers, such as counselors, are the essential link between the program and the consumer. Service providers are in a unique position to judge the quality of the services being provided and the extent to which they match the needs of the community. The provider survey yields a systematic, standardized assessment of providers' opinions and reactions to their work.

What's in the survey?

The 2-page survey has several parts. The first section asks how often the respondent performed several CCP direct service functions. Workers who answer that they *never* perform any of these functions are instructed to discontinue the survey. The next section asks staff to evaluate the training, support, supervision, and opportunities for growth provided by the work. This section also asks about the appropriateness of the workload and the adequacy of resources and tools available, and for the provider's evaluation of the services provided by the CCP. The section that follows is composed of 6 questions from the SPRINT-E (the reaction measure used in the Assessment/Referral Tool and the Participant Survey). These questions examine whether the work, or the provider's reaction to it, has caused problems in other areas of their lives. A section on demographics and a place for comments complete this survey.

When and how is it done?

These data would be collected anonymously from direct service providers (including outreach, education, counseling, and supervision) at 6 and 12 months postevent. Supervisors would distribute the survey to counselors together with a stamped envelope, addressed to an external evaluator.

How are counselors protected?

Some counselors could understandably be concerned that supervisors or program directors could figure out who they are even though the survey is completed anonymously. The completed survey is mailed to an external evaluator so that it does not go through local program management. Regardless of the number of workers, provider surveys are collected for the cumulative national database. Results are shared with local program management only if the number of individual workers is greater than 20. When results are shared, they are shown only in aggregations large enough to ensure that individual counselors or small groups of counselors are not identifiable.

Data Management and Analysis

How are the forms produced?

The forms were designed to be scannable. This attribute makes data entry much easier, but it means that more care is required when forms are produced. Production needs differ between the one-page forms and the two-page forms.

The three forms that are used most often (encounter logs, weekly tally) are one-sided. They may be printed on a good quality printer or photocopied.

Because of the volume of forms, it often makes sense for programs to contract with a professional tele-form vendor.

Why are the 2-pagers different?

The three specialty forms that are used less often (assessment & referral tool, participant survey, provider survey) require special care because they are two pages long. These forms must be reproduced using tele-form software. The software generates a unique bar code for each form so that the information on the back of the page for a particular individual stays with the information on the front of the page for that same individual. Therefore, these forms should never be photocopied. If Person B's form is a photocopy of Person A's form, the computer cannot tell whether page 2 belongs to Person A or Person B.

It is recommended that programs either (a) contract with a teleform vendor to produce these forms or (b) purchase the software and train a staff person in how to use it for survey and referral tool production.

How are the forms filled in?

The tools have been designed to require little more than numbers or Xs in boxes that correspond to the selected answer. The marks should be made firmly and neatly with a good quality black ballpoint or roller ball pen. Pencils, colored ink, and older felt tip pens sometimes leave gaps that make the forms more difficult for scanners to read.

Where do completed tools go?

Counselors turn in completed individual and group encounter logs, weekly tallies, and assessment & referral tools to their supervisors. Participant and provider surveys are mailed directly to an external evaluator.

How often are they submitted?

Programs can decide whether completed encounter logs are to be submitted daily or weekly. In large programs serving many people, it is better to do this on a daily basis so that the work does not pile up. The supervisor is responsible for telling counselors the procedure for their setting. Tallies of brief educational and supportive services are submitted by counselors to their supervisors on a weekly basis.

What do supervisors do?

Supervisors check the completeness of submitted tools and note repeated errors. If repeated errors appear to be due to the tool's instructions, a member of the evaluation team should be informed. Supervisors will be given this contact for their specific program. If repeated errors appear to be due to the counselor failing to follow the instructions, the counselor should be shown what to do in the future. It is likely that the most time-consuming part of the supervisor's oversight is dealing with counselor errors, so good counselor training is important. Supervisors sign, initial, or stamp each form to show that it has been checked. The supervisor designates a spot for the checked forms, bundling together forms of a specific type (e.g., individual counseling encounter log).

What happens next?

Local procedures vary according to the needs and size of the program. Often, a designated evaluation coordinator or some other courier is responsible for visiting each location to pick up the bundles of completed tools. In some locations, faxing the forms to a designated computer is a good option.

How are the data entered?

Because the tools are scannable, data entry is quick and efficient. With the appropriate equipment, over 30 pages can be scanned per minute per scanner into databases that compile the information contained on each form. Various databases are necessary -- one file for the individual encounter data, etc. A code on the bottom right-hand side of the form tells the computer where to route the data.

A data technician scans the forms as they come in from the field. This person then "verifies" the data when uncertainties arise. Sometimes the computer may indicate uncertainty about the correct value for a field (for example, whether a number was a "0" or "6"). When the forms have been marked neatly and firmly in black ink, few uncertainties arise in the verification step.

Who is responsible for this?

This differs by form. Programs are responsible for scanning and verifying the data from encounter logs, weekly tallies, and assessment and referral tools. They may do this step internally, or they may contract it out. Participant and provider surveys are scanned by an external evaluation team.

What resources are needed?

Total resources needed to conduct this evaluation vary greatly with program size. It is estimated that one counselor will generate an average of 30 pages of forms per week. The cost of printing forms may range from 50¢ to $1 per counselor per week. Roughly, the work of one crisis counselor would take 1 minute per week to scan and four minutes to check. Once scanned and checked, the original forms can be destroyed, reducing storage costs and space needs.

If the work is being done in-house, relatively large programs can function with 2 scanners (the second for redundancy and periods of peak volume), one data technician, and one evaluation coordinator. Highly complex or widespread programs may need additional staff and scanners for different regions of the state. Small programs may combine the technician and coordinator roles into a single position, and very small programs may outsource data entry and assign the coordination role to another staff member.

How are the data organized?

The database is a matrix or “spreadsheet” with variables along the top (columns) and units along the sides (rows). At the data’s most detailed level, each form is the unit or case. This approach allows maximum flexibility in answering questions of interest to the state, some of which may arise during the course of the program.

Once all the forms are entered, the data can then be aggregated in a number of different ways to answer different types of questions. For example, in a second database for individual counseling, data could be aggregated by county and time, where the unit is county-week (for example one row is the data for County A, Week 1).

Summary data across forms can be merged as well. For the database in which county is the unit of analysis, these data can be further merged with data about the event (e.g., needs assessment projections) and population (e.g., density, % poverty). Likewise, at the conclusion of a program, the data are aggregated to the program level and merged with data from other crisis counseling programs.

How are the data analyzed?

Too much information is as confusing as too little, so it is critical that management work together with experienced evaluators and expert analysts who can extract and distill the data into usable bits of information. Because of the hierarchical nature of the data (counselors embedded in counties embedded in states and everything embedded in time), considerable statistical skill is necessary to analyze the data appropriately.

What are some examples?

One example of information that can be produced and updated weekly is a table that summarizes all services provided by type, location, and time. Another example would be a chart comparing individual counseling data to population data on key demographic characteristics. For example, counties with a higher percentage of African Americans in the population should have a higher percentage of African Americans in individual counseling. Yet another example is a comparison between severely and less severely stricken areas in the distress levels and satisfaction ratings of crisis counseling participants.

Is this evaluation enough?

This evaluation plan may or may not be enough depending upon the size and complexity of the program. Good evaluators assist program planners and managers to identify other information needs specific to their locations that are not part of the evaluation required by the sponsor. For example, as the program unfolds, innovative approaches may emerge that warrant special evaluation procedures that capture outcomes as well as outputs. There could be occasions where the program needs qualitative data on selected, focused issues. In other words, the plan described here provides basic information on service reach, quality, and consistency, but does not preclude the possibility of states adding other components to their own program evaluations.

Tools and Instructions

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